2SSB 5346 - H COMM AMD
By Committee on Health Care & Wellness

ADOPTED 04/13/2009

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that:

(1) The health care system in the nation and in Washington state costs nearly twice as much per capita as other industrialized nations.

(2) The fragmentation and variation in administrative processes prevalent in our health care system contribute to the high cost of health care, putting it increasingly beyond the reach of small businesses and individuals in Washington.

(3) In 2006, the legislature's blue ribbon commission on health care costs and access requested the office of the insurance commissioner to conduct a study of administrative costs and recommendations to reduce those costs. Findings in the report included:

(a) In Washington state approximately thirty cents of every dollar received by hospitals and doctors' offices is consumed by the administrative expenses of public and private payors and the providers;

(b) Before the doctors and hospitals receive the funds for delivering the care, approximately fourteen percent of the insurance premium has already been consumed by payor administration. The payor's portion of expense totals approximately four hundred fifty dollars per insurance member per year in Washington state;

(c) Over thirteen percent of every dollar received by a physician's office is devoted to interactions between the provider and payor;

(d) Between 1997 and 2005, billing and insurance related costs for hospitals in Washington grew at an average pace of nineteen percent per year; and

(e) The greatest opportunity for improved efficiency and administrative cost reduction in our health care system would involve standardizing and streamlining activities between providers and payors.

(4) To address these inefficiencies, constrain health care inflation, and make health care more affordable for Washingtonians, the legislature seeks to establish streamlined and uniform procedures for payors and providers of health care services in the state. It is the intent of the legislature to foster a continuous quality improvement cycle to simplify health care administration. This process should involve leadership in the health care industry and health care purchasers, with regulatory oversight from the office of the insurance commissioner.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Commissioner" means the insurance commissioner as established under chapter 48.02 RCW.

(2) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005 and, for the purposes of this act, shall include facilities licensed under chapter 70.41 RCW.

(3) "Lead organization" means a private sector organization or organizations designated by the commissioner to lead development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state.

(4) "Medical management" means administrative activities established by the payor to manage the utilization of services through preservice or postservice reviews. "Medical management" includes, but is not limited to:

(a) Prior authorization or preauthorization of services;

(b) Precertification of services;

(c) Postservice review;

(d) Medical necessity review; and

(e) Benefits advisory.

(5) "Payor" means public purchasers, as defined in this section, carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62 RCW, and the Washington state health insurance pool established in chapter 48.41 RCW.

(6) "Public purchaser" means the department of social and health services, the department of labor and industries, and the health care authority.

(7) "Secretary" means the secretary of the department of health.

(8) "Third-party payor" has the same meaning as in RCW 70.02.010.

NEW SECTION. **Sec. 3.** A new section is added to chapter 70.14 RCW to read as follows:

The following state agencies are directed to cooperate with the insurance commissioner and, within funds appropriated specifically for this purpose, adopt the processes, guidelines, and standards to streamline health care administration pursuant to sections 2, 5, 6, and 8 through 10 of this act: The department of social and health services, the health care authority, and, to the extent permissible under Title 51 RCW, the department of labor and industries.

Sec. 4. RCW 70.47.130 and 2004 c 115 s 2 are each amended to read as follows:

(1) The activities and operations of the Washington basic health plan under this chapter, including those of managed health care systems to the extent of their participation in the plan, are exempt from the provisions and requirements of Title 48 RCW except:

(a) Benefits as provided in RCW 70.47.070;

(b) Managed health care systems are subject to the provisions of RCW 48.43.022, 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, and 70.02.900;

(c) Persons appointed or authorized to solicit applications for enrollment in the basic health plan, including employees of the health care authority, must comply with chapter 48.17 RCW. For purposes of this subsection (1)(c), "solicit" does not include distributing information and applications for the basic health plan and responding to questions; ((~~and~~))

(d) Amounts paid to a managed health care system by the basic health plan for participating in the basic health plan and providing health care services for nonsubsidized enrollees in the basic health plan must comply with RCW 48.14.0201; and

(e) Administrative simplification requirements as provided in this act.

(2) The purpose of the 1994 amendatory language to this section in chapter 309, Laws of 1994 is to clarify the intent of the legislature that premiums paid on behalf of nonsubsidized enrollees in the basic

health plan are subject to the premium and prepayment tax. The legislature does not consider this clarifying language to either raise existing taxes nor to impose a tax that did not exist previously.

NEW SECTION. **Sec. 5.** (1) The commissioner shall designate one or more lead organizations to coordinate development of processes, guidelines, and standards to streamline health care administration and to be adopted by payors and providers of health care services operating in the state. The lead organization designated by the commissioner for this act shall:

(a) Be representative of providers and payors across the state;

(b) Have expertise and knowledge in the major disciplines related to health care administration; and

(c) Be able to support the costs of its work without recourse to public funding.

(2) The lead organization shall:

(a) In collaboration with the commissioner, identify and convene work groups, as needed, to define the processes, guidelines, and standards required in sections 6 through 10 of this act;

(b) In collaboration with the commissioner, promote the participation of representatives of health care providers, payors of health care services, and others whose expertise would contribute to streamlining health care administration;

(c) Conduct outreach and communication efforts to maximize adoption of the guidelines, standards, and processes developed by the lead organization;

(d) Submit regular updates to the commissioner on the progress implementing the requirements of this act; and

(e) With the commissioner, report to the legislature annually through December 1, 2012, on progress made, the time necessary for completing tasks, and identification of future tasks that should be prioritized for the next improvement cycle.

(3) The commissioner shall:

(a) Participate in and review the work and progress of the lead organization, including the establishment and operation of work groups for this act;

(b) Adopt into rule, or submit as proposed legislation, the guidelines, standards, and processes set forth in this act if:

(i) The lead organization fails to timely develop or implement the guidelines, standards, and processes set forth in sections 6 through 10 of this act; or

(ii) It is unlikely that there will be widespread adoption of the guidelines, standards, and processes developed under this act;

(c) Consult with the office of the attorney general to determine whether an antitrust safe harbor is necessary to enable licensed carriers and providers to develop common rules and standards; and, if necessary, take steps, such as implementing rules or requesting legislation, to establish such safe harbor; and

(d) Convene an executive level work group with broad payor and provider representation to advise the commissioner regarding the goals and progress of implementation of the requirements of this act.

NEW SECTION. **Sec. 6.** By December 31, 2010, the lead organization shall:

(1) Develop a uniform electronic process for collecting and transmitting the necessary provider-supplied data to support credentialing, admitting privileges, and other related processes that:

(a) Reduces the administrative burden on providers;

(b) Improves the quality and timeliness of information for hospitals and payors;

(c) Is interoperable with other relevant systems;

(d) Enables use of the data by authorized participants for other related applications; and

(e) Serves as the sole source of credentialing information required by hospitals and payors from providers for data elements included in the electronic process, except this shall not prohibit:

(i) A hospital, payor, or other credentialing entity subject to the requirements of this section from seeking clarification of information obtained through use of the uniform electronic process, if such clarification is reasonably necessary to complete the credentialing process; or

(ii) A hospital, payor, other credentialing entity, or a university from using information not provided by the uniform process for the purpose of credentialing, admitting privileges, or faculty appointment of providers, including peer review and coordinated quality improvement information, that is obtained from sources other than the provider;

(2) Promote widespread adoption of such process by payors and hospitals, their delegates, and subcontractors in the state that credential health professionals and by such health professionals as soon as possible thereafter; and

(3) Work with the secretary to assure that data used in the uniform electronic process can be electronically exchanged with the department of health professional licensing process under chapter 18.122 RCW.

NEW SECTION. **Sec. 7.** A new section is added to chapter 18.122 RCW to read as follows:

Pursuant to sections 5 and 6 of this act, the secretary or his or her designee shall participate in the work groups and, within funds appropriated specifically for this purpose, implement the standards to enable the department to transmit data to and receive data from the uniform process.

NEW SECTION. **Sec. 8.** The lead organization shall:

(1) Establish a uniform standard companion document and data set for electronic eligibility and coverage verification. Such a companion guide will:

(a) Be based on nationally accepted ANSI X12 270/271 standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally recognized organizations, such as the centers for medicare and medicaid services;

(b) Enable providers and payors to exchange eligibility requests and responses on a system-to-system basis or using a payor supported web browser;

(c) Provide reasonably detailed information on a consumer's eligibility for health care coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing requirements for specific services at the specific time of the inquiry, current deductible amounts, accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and other information required for the provider to collect the patient's portion of the bill; and

(d) Reflect the necessary limitations imposed on payors by the originator of the eligibility and benefits information;

(2) Recommend a standard or common process to the commissioner to protect providers and hospitals from the costs of, and payors from

claims for, services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request; and

(3) Complete, disseminate, and promote widespread adoption by payors of such document and data set by December 31, 2010.

NEW SECTION. **Sec. 9.** (1) By December 31, 2010, the lead organization shall develop implementation guidelines and promote widespread adoption of such guidelines for:

(a) The use of the national correct coding initiative code edit policy by payors and providers in the state;

(b) Publishing any variations from component codes, mutually exclusive codes, and status b codes by payors in a manner that makes for simple retrieval and implementation by providers;

(c) Use of health insurance portability and accountability act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(d) The processing of corrections to claims by providers and payors; and

(e) A standard payor denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common standards body or process exists and multiple conflicting sources are in use by payors and providers.

(2) By October 31, 2010, the lead organization shall develop a proposed set of goals and work plan for additional code standardization efforts for 2011 and 2012.

(3) Nothing in this section or in the guidelines developed by the lead organization shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. Though such temporary code edits are not required to be disclosed to providers, the guidelines shall require that:

(a) Each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such an edit; and

(b) The provider have access to the payor's review and appeal process to challenge the payor's adjudication decision, provided that nothing in this subsection (3)(b) shall be construed to modify the rights or obligations of payors or providers with respect to procedures relating to the investigation, reporting, appeal, or prosecution under applicable law of potentially fraudulent billing activities.

NEW SECTION. **Sec. 10.** (1) By December 31, 2010, the lead organization shall:

(a) Develop and promote widespread adoption by payors and providers of guidelines to:

(i) Ensure payors do not automatically deny claims for services when extenuating circumstances make it impossible for the provider to: (A) Obtain a preauthorization before services are performed; or (B) notify a payor within twenty-four hours of a patient's admission; and

(ii) Require payors to use common and consistent time frames when responding to provider requests for medical management approvals. Whenever possible, such time frames shall be consistent with those established by leading national organizations and be based upon the acuity of the patient's need for care or treatment;

(b) Develop, maintain, and promote widespread adoption of a single common web site where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements;

(c) Establish guidelines for payors to develop and maintain a web site that providers can employ to:

(i) Request a preauthorization, including a prospective clinical necessity review;

(ii) Receive an authorization number; and

(iii) Transmit an admission notification.

(2) By October 31, 2010, the lead organization shall propose to the commissioner a set of goals and work plan for the development of medical management protocols, including whether to develop evidence-based medical management practices addressing specific clinical conditions and make its recommendation to the commissioner, who shall report the lead organization's findings and recommendations to the legislature.

NEW SECTION. **Sec. 11.** Sections 2, 5, 6, and 8 through 10 of this act constitute a new chapter in Title 48 RCW."

Correct the title.

EFFECT: Clarifies that the review process developed under section 9(1)(e) of this act is not the standard appeal process in RCW 48.43.530.

Provides that if a payor uses temporary code edits to detect fraudulent billing activities, it must disclose its adjudication decision on a claim and allow the provider to use the payor's review and appeal process to challenge the adjudication decision.

Provides greater flexibility to the lead organization in selecting which national organization to base common and consistent time frames on.

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